## APPLICATION FOR REQUEST FOR RELIEF FROM THE COVID-19 EMERGENCY HEALTHCARE SYSTEM RELIEF FUND IN ACCORDANCE WITH EMERGENCY ORDER #9 PURSUANT TO EXECUTIVE ORDER 2020-04

PLEASE COMPLETE THIS APPLICATION IN ITS ENTIRETY.

**Missing or incomplete information will only result in processing delays**.

**Submit completed requests to:** healthcarerelieffund@dhhs.nh.gov along with any supporting documentation you wish to be considered in making your request for relief.

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| --- | --- |
| **Date of Application:** |  |

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| --- | --- |
| **Applicant is:****(please check one)** |  [ ]  Hospital |
|  [ ]  Other: Please specify |

|  |
| --- |
| **Organization’s Name:**  |
| **Organization’s Physical Address:** | Address: |
| City | State | Zip |
| **Organization’s Mailing Address:** | Address: |
| City | State | Zip |
| **Contact Person’s Name:** |  |
| **Contact Person’s Telephone:** | Business | Cell |
| **Contact Person’s** **Email:** |  |

|  |  |
| --- | --- |
| **Amount of Funds Requested:**  |  |
| **Describe how the funds will be used:**  |  |
| **Explain why the funds are necessary for the maintenance of an essential component of the State’s healthcare system during the COVID-19 state of emergency:**  |  |
| **Explain what will happen if your request is denied:**  |  |

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| **Applicant’s Certification:**  |
| I do hereby certify that all information provided in or attached to this application is complete, accurate, and up-to-date as of the date specified below. I further certify that there are no willful misrepresentations of the answers to questions herein, and that I have made no omissions with respect to any of my answers to the questions presented. I understand that it is my responsibility to immediately notify the department in regard to any changes, corrections, or updates to the information provides, using the email address: healthcarerelieffund@dhhs.nh.gov. I also understand that this application is being submitted to determine eligibility for relief from the COVID-19 Emergency Healthcare System Relief Fund in accordance with Emergency Order #9 pursuant to Executive Order 2020-04. I also understand that any decision on this application is subject to approval by the Governor’s Office and no funds will be disbursed without his prior written approval. Dated:  Applicant Signature   Print Name |

**DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY**

Date Application Received: Date Application Reviewed:

Date Application Approved:

Commissioner/Designee Application Approved by:

 Name/Title

Finance/Designee Application Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name/Title